Residual Functional Capacity Questionnaire
THYROID

Patient: _____

DOB: _____

Physician completing this form: _____

Please complete the following questions regarding this patient's impairments and attach all supporting treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

What diagnoses has this patient received? _____

_____

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc._____

_____

_____

Does the patient have chronic pain/paresthesia? ☐ Yes ☐ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity._____

_____

_____

Please indicate all positive objective signs exhibited by the patient:

☐ Graves disease	☐ Goiter	☐ Chronic fatigue/lethargy
☐ Enlarged lymphnodes	☐ Vocal cord impairment	☐ Weakness
☐ Heat/cold intolerance	☐ Depression/anxiety	☐ Constipation
☐ Weight change	☐ Hoarseness	☐ Menorrhagia
☐ Anemia	☐ Hyponatremia	☐ Arthralgias/myalgias
☐ Muscle cramps	☐ Dry skin	☐ Frequent headaches
☐ Peripheral edema	☐ Pallor	☐ Dyspnea
☐ Diminished hearing	☐ Myxedema heart	☐ Ophthalmopathy

☐ Other: _____

What is the earliest date that the above description of limitations applies? _____

Have these symptoms lasted (or are they expected to last) twelve months or longer? ☐ Yes ☐ No

Are this patient's symptoms and functional limitations impacted by emotional factors? ☐ Yes ☐ No

If yes, please mark any known psychological conditions that affect this patient's pain:

☐ Depression ☐ Anxiety ☐ Somatoform disorder ☐ Personality disorder

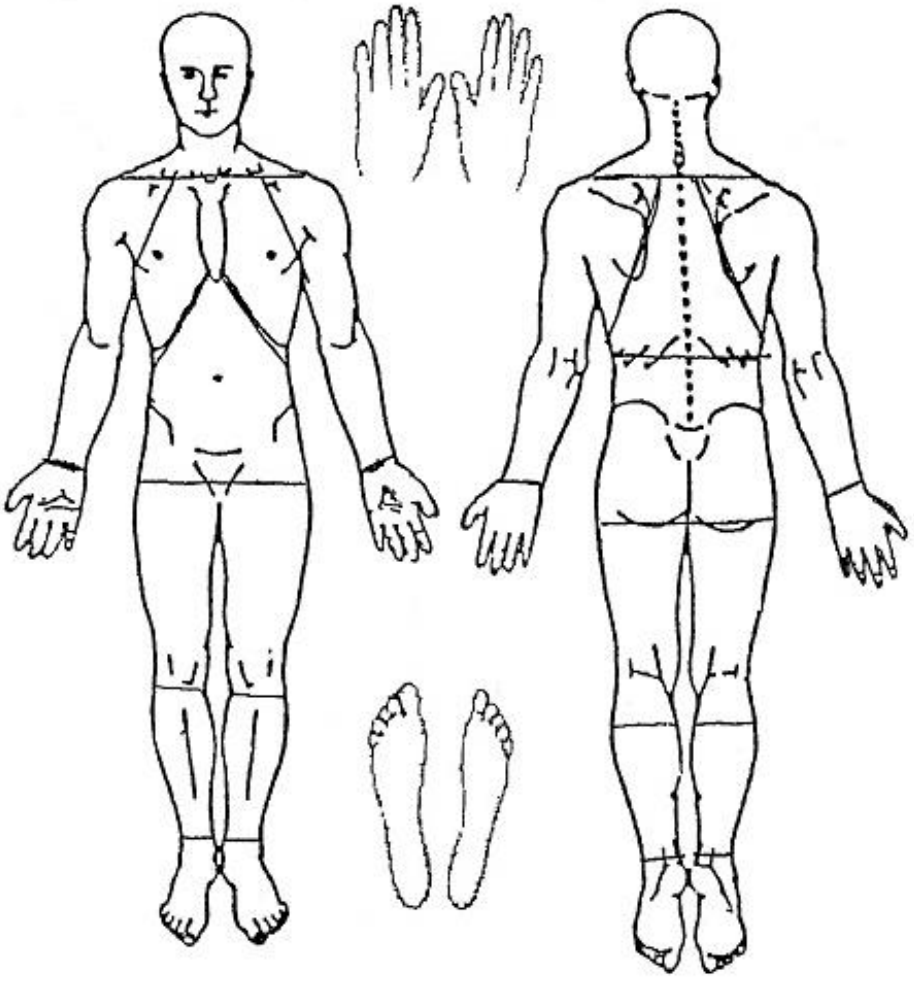
☐ Other: _____

Are these physical and emotional impairments reasonably consistent with the patient's symptoms and functional limitations? ☐ Yes ☐ No

If no, please explain: _____

Testing & Treatments

Identify the location and frequency of the patient's pain/paresthesia by shading the relevant body areas and labeling each as Constant (C), Frequent (F), or Occasional (O)



Identify any positive clinical findings and test results, such as TSH, FT4, ultrasounds, scans, FNA/biopsy:

_____

_____

Please list the patient's current medications:_____

_____

Please indicate the treatment type, start dates, and frequency: _____

_____

_____

What is the patient's prognosis? _____

Is this patient a malingerer? ☐ Yes ☐ No

Functional Work Limitations

When answering the following questions, please consider this patient's impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

How often do you expect this patient's pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?

- ☐ Never
- ☐ Rarely (1% to 5% of an 8 hour working day)
- ☐ Occasionally (6% to 33% of an 8 hour working day)
- ☐ Frequently (34% to 66% of an 8 hour working day)
- ☐ Constantly

How well do you expect this patient to be able to tolerate work stress?

- ☐ Incapable of even "low stress" jobs
- ☐ Only capable of low stress jobs
- ☐ Moderate stress is okay
- ☐ Capable of high stress situations

Explain: _____

_____

Is this patient taking any medications with side effects that may affect his or her ability to work?

☐ Yes ☐ No

If yes, please list possible side effects. _____

_____

Which aspects of workplace stress is your patient unable to tolerate?

- ☐ Public contact
- ☐ Routine, Repetitive Tasks at Consistent Pace
- ☐ Detailed or Complicated Tasks
- ☐ Strict Deadlines
- ☐ Close Interaction with Co-Workers/Supervisors
- ☐ Fast Paced Tasks, such as a production line
- ☐ Exposure to Work Hazards, such as heights or moving machinery
- ☐ Other:_____

How far can this patient walk without rest or severe pain? _____

How long can this patient sit comfortably at one time before needing to get up?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Stand ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient stand comfortably at one time before needing to sit or walk around?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Sit ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient sit in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

Might the patient require additional unscheduled breaks to lie down, change soiled clothing, or rest at unpredictable times? ☐ Yes ☐ No

If yes, how many times? 1 2 3 4 5 6 7 8 9 10 >10
For how many minutes? <5 5 10 20 30 45 60 90 >90
For which symptoms?
☐ Chronic fatigue ☐ Medication side effects ☐ Pain/paresthesia
☐ Other: _____

During occasional standing/walking, does this patient require a cane or other assistive device?

☐ Yes ☐ No
For which symptoms?
☐ Edema ☐ Pain ☐ Other: _____

How many pounds can this patient lift and carry?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

How often can the patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

Does this patient have significant limitations with repetitive reaching, handling or fingering?

☐ Yes ☐ No
If yes, please indicate the percentage of time this patient can perform the following activities:
Using hands to grasp, turn and twist objects Right _____% Left _____%
Using fingers for fine manipulation Right _____% Left _____%
Using arms to reach out and overhead Right _____% Left _____%

Are this patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No
If yes, please estimate, on average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:
☐ Never ☐ About three days per month
☐ About one day per month ☐ About four days per month
☐ About two days per month ☐ More than four days per month

Please describe any other limitations that might affect this patient's ability to work at a regular job on a sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.

_____

_____

_____

_____

Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

_____

_____

_____

_____

Completed by:

_____ _____

Physican's Printed Name Physician's Signature

_____ _____

Address Date

_____

_____